PROFESSIONAL EVALUATION/ DOCUMENTATION OF DISABILITY/CONDITION

CALIFORNIA STATE BOARD OF PHARMACY
1625 N. MARKET BLVD, SUITE N219, SACRAMENTO, CA 95834
TELEPHONE:(916) 574-7900
WEBSITE ADDRESS: http://www.pharmacy.ca.gov

Name of Applicant _____

Evaluator's Name _____

USE OF THIS FORM BY AN EVALUATOR IS OPTIONAL. HOWEVER, IF THIS FORM IS NOT USED, ALL THE INFORMATION REQUESTED SHOULD BE PROVIDED ON ORIGINAL LETTERHEAD STATIONERY OF THE EVALUATOR..

1. Describe the credentials and experience, which qualify you, the evaluator, in the area of practice relative to the specific disability or condition to make the determination of the disability and the recommended accommodation. (See Section III.)

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2. Does the applicant have a mental or physical disability or medical condition? ____ Yes _____ No

3. Describe the candidate's type of mental or physical disability or medical condition. If applicable, please include DSM Code, date of assessment, the tests used to diagnose the disability or medical condition , and a summary of the interpretation of the test results.

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4. Describe the nature and extent of the disability or condition (e.g., hearing impaired, diabetic, dyslexia; severe, moderate, mild), how the disability or condition limits one or more of the candidate's major life activities, and if the disability will change in any way over time.

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5. What is the recommended accommodation and how does the accommodation relate to the candidate's disability or condition given the format of the examination? Please be specific (e.g., if additional time is needed, indicate how much; if additional breaks, how many and with what frequency).

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Evaluator's Name (Print) Type of Professional License or Certification Number

Signature Date Business Name Telephone Number